

**Centers for Medicare & Medicaid Services, HHS**

**§ 447.54**

(2) *Pregnant women.* Services furnished to pregnant women if such services related to the pregnancy, or to any other medical condition which may complicate the pregnancy are excluded from cost sharing obligations. These services include routine prenatal care, labor and delivery, routine postpartum care, family planning services, complications of pregnancy or delivery likely to affect the pregnancy, such as hypertension, diabetes, urinary tract infection, and services furnished during the postpartum period for conditions or complications related to the pregnancy. The postpartum period is the immediate postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends. States may further exclude from cost sharing all services furnished to pregnant women if they desire.

(3) *Institutionalized individuals.* Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution if the individual is required (pursuant to § 435.725, § 435.733, § 435.832, or § 436.832), as a condition of receiving services in the institution, to spend all but a minimal amount of his income required for personal needs, for medical care costs are excluded from cost sharing.

(4) *Emergency services.* Services as defined at section 1932(b)(2) of the Act and § 438.114(a).

(5) *Family planning.* Family planning services and supplies furnished to individuals of child-bearing age are excluded from cost sharing.

(6) *Indians.* Items and services furnished to an Indian directly by an Indian health care provider or through referral under contract health services.

(c) *Prohibition against multiple charges.* For any service, the plan may not impose more than one type of charge referred to in paragraph (a) of this section.

(d) *State plan specifications.* For each charge imposed under this section, the plan must specify—

- (1) The service for which the charge is made;
- (2) The amount of the charge;

(3) The basis for determining the charge;

(4) The basis for determining whether an individual is unable to pay the charge and the means by which such an individual will be identified to providers; and

(5) The procedures for implementing and enforcing the exclusions from cost sharing found in paragraph (b) of this section.

(e) No provider may deny services, to an individual who is eligible for the services, on account of the individual's inability to pay the cost sharing.

[43 FR 45253, Sept. 29, 1978, as amended at 47 FR 21051, May 17, 1982; 48 FR 5736, Jan. 8, 1983; 50 FR 23013, May 30, 1985; 55 FR 48611, Nov. 21, 1990; 55 FR 52130, Dec. 19, 1990; 67 FR 41116, June 14, 2002; 75 FR 30261, May 28, 2010]

**§ 447.54 Maximum allowable and nominal charges.**

Except as provided at §§ 447.62 through 447.82 of this part, the following requirements must be met:

(a) *Non-institutional services.* Except as specified in paragraph (b) of this section, for non-institutional services, the plan must provide that the following requirements are met:

(1) For Federal FY 2009, any deductible it imposes does not exceed \$2.30 per month per family for each period of Medicaid eligibility. For example, if Medicaid eligibility is certified for a 6-month period, the maximum deductible which may be imposed on a family for that period of eligibility is \$13.80. In succeeding years, any deductible may not exceed these amounts as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year, and then rounded to the next higher 5-cent increment.

(2) Any coinsurance rate it imposes does not exceed 5 percent of the payment the agency makes for the services; and

(3)(i) For Federal FY 2009, any co-payments it imposes under a fee-for-service delivery system do not exceed the amounts shown in the following table:

State payment for the service	Maximum copayment
\$10 or less .....	\$0.60

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State payment for the service	Maximum copayment
\$10.01 to \$25 .....	1.15
\$25.01 to \$50 .....	2.30
\$50.01 or more .....	3.40

(ii) Thereafter, any copayments may not exceed these amounts as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(4) For Federal FY 2009, any copayment that the State imposes for services provided by a managed care organization (MCO) may not exceed the copayment permitted under paragraph (a)(3)(i) of this section for comparable services under a fee-for-service delivery system. When there is no fee-for-service delivery system, the copayment may not exceed \$3.40 per visit. In succeeding years, any copayment may not exceed these amounts as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(b) *Waiver of the requirement that cost sharing amounts be nominal.* Upon approval from CMS, the requirement that cost sharing charges must be nominal may be waived, in accordance with sections 1916(a)(3) and 1916(b)(3) of the Act and § 431.57 of this chapter, for non-emergency services furnished in a hospital emergency department, if the State establishes to the satisfaction of the Secretary that alternative sources of nonemergency, outpatient services are actually available and accessible to Medicaid beneficiaries in a timely manner.

(b) *Waiver of the requirement that cost sharing amounts be nominal.* Upon approval from CMS, the requirement that cost sharing charges must be nominal may be waived, in accordance with section 431.55(g) for nonemergency services furnished in a hospital emergency room.

(c) *Institutional services.* For institutional services, the plan must provide that the maximum deductible, coinsurance or co-payment charge for each admission does not exceed 50 percent of

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the payment the agency makes for the first day of care in the institution.

(d) *Cumulative maximum.* The plan may provide for a cumulative maximum amount for all deductible, coinsurance or co-payment charges that it imposes on any family during a specified period of time.

[48 FR 5736, Jan. 8, 1983, as amended at 73 FR 71851, Nov. 25, 2008; 75 FR 30262, May 28, 2010]

### § 447.55 Standard co-payment.

(a) The plan may provide for a standard, or fixed, co-payment amount for any service.

(b) This standard copayment amount for any service may be determined by applying the maximum copayment amounts specified in § 447.54(a) and (c) to the agency's average or typical payment for that service. For example, if the agency's typical payment for prescribed drugs is \$4 to \$5 per prescription, the agency might set a standard copayment of \$.60 per prescription. This standard copayment may be adjusted based on updated copayments as permitted under § 447.54(a)(3).

[43 FR 45253, Sept. 29, 1978, as amended at 73 FR 71851, Nov. 25, 2008; 75 FR 30262, May 28, 2010]

### § 447.56 Income-related charges.

Subject to the maximum allowable charges specified in § 447.54 (a) and (b), the plan may provide for income-related deductible, coinsurance or co-payment charges. For example, an agency may impose a higher charge on medically needy recipients than it imposes upon categorically needy recipients.

### § 447.57 Restrictions on payments to providers.

(a) The plan must provide that the agency does not increase the payment it makes to any provider to offset uncollected amounts for deductibles, coinsurance, copayments or similar charges that the provider has waived or are uncollectable, except as permitted under paragraph (b) of this section.

(b) For those providers that the agency reimburses under Medicare reasonable cost reimbursement principles, in accordance with subpart B of this part, an agency may increase its payment to